Linkage

Vol. 11, No. 1 Spring 2001

FROM THE OFFICE OF THE DIRECTOR

Strengthening the PMHS

By Oscar Morgan

Spring is the time of year that those of us in the mental health system begin to focus greater attention on community awareness initiatives, highlighting early identification in the prevention of serious illness. May is **National Mental Health Month** and many activities throughout the State are being planned to reach out to local communities in addressing mental health issues and identifying available services.

While we are continuing our commitment to existing services, and remain open to adding new programs to meet the growing need of communities, it has become apparent over the recent months that the increased demand on the Public Mental Health System (PMHS) has far exceeded our rate of expectation. When changes were made in 1997 to the PMHS, the goals were to increase access for consumers, increase the number and variety of service providers, and ensure that those services were delivered in an efficient and effective manner. Prior to those changes, approximately 40,000 individuals – those uninsured or on Medical Assistance received services. Today, approximately 80,000 individuals receive PMHS services. Of that number, 41 percent are children, up from 25 percent in 1997. In 1997 there were only 200 programs and very few active individual providers within the PMHS. Today, the PMHS has over 4,000 individual providers and / or programs available State-wide to address community mental health needs. The result of this dramatic increase is a more competitive mental health system.

However, the new PMHS presented itself with additional challenges. Some providers' continued viability raised concern. Additional technical assistance was and continues to be made available to address these and other issues. In presenting a more equitable reimbursement system within the PMHS, compared to those paid by private insurance companies, we increased rates twice since the inception of the new PMHS. The PMHS continues to meet with mental health advocates, consumers, families, and providers to ensure that the system reflects their need. In particular, the PMHS continues to refine its system to ensure that the uninsured – the largest growing segment of those needing mental health services – receive necessary care. While trying to meet those demands, and in addition trying to accommodate other individuals whose insurance companies do not adequately cover mental health services, the need for services

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The Mental Hygiene Administration, The Maryland Department of Health and Mental Hygiene

Parris N. Glendening, *Governor*

Kathleen Kennedy Townsend, *Lt. Governor*

Georges C. Benjamin, MD *Secretary*, *Department of Health and Mental Hygiene*

Maryland's PMHS *Continued*

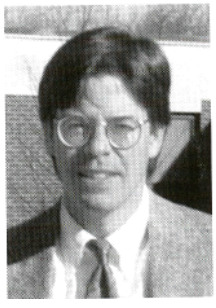
is now exceeding available resources.

As a result, increased pressure is being experienced throughout the mental health community. More than any other year, this year's Legislative session saw a more united mental health community advocating toward one essential goal – ensuring that the PMHS remains adequately funded to address the increased demands. Notably, individuals who are currently receiving mental health services need to be able to have the full spectrum of services available to ensure that the most appropriate care is received. Early identification efforts in the prevention of serious illness must continue to be emphasized to ensure that those needing services receive the necessary mental health care. Access and choice are important to consumers, and prompt and adequate payments are critical for providers. All are of equal importance to the PMHS, yet most important to the overall system is meeting the consumers' needs. Two recent consumer satisfaction surveys indicated that 80 percent of those receiving services were pleased with the services provided, and approximately the same number believed that they benefited from the program.

In fiscal year 1997, $330 million was spent for community-based services. Currently, approximately $395 million is being spent – a 19.7 percent increase. Yet service need continues to rise. We received an additional 30 million dollars to address the expanded need, 2 million dollars for school-based prevention initiatives and 8 million dollars for addressing other unmet needs. We are appreciative of the Governor, the Lt. Governor, and members of the General Assembly for their support of the PMHS. ***For a copy of Mental Health Month activities, call 410-402-7517.***

Advance Directives for Mental Health Services

By W. Lawarence Fitch, J. D., Director, MHA Office of Forensic Services



On the last day of its 2001 session, the Maryland General Assembly passed House Bill 752, providing for the development of advance directives for mental health services. Introduced by Delegate Samuel Rosenberg, D-Baltimore, House Bill 752, if signed by the Governor, will authorize any individual, while legally competent, to make an advance directive specifying services the individual would prefer if he or she became incompetent and had a need for mental health services in the future. Procedures for making and revoking an advance directive for mental health services under House Bill 752 are governed by the Health Care Decision Act, Health – General § 5-601 et seq. House Bill 752 provides **that** an advance directive for mental health services may include:

- the designation of an agent to make mental health services decisions for the individual;
- the identification of mental health professionals, programs, and facilities that the individual would prefer to provide mental health services;
- a statement of medications preferred by the individual for psychiatric treatment; and
- instructions regarding the notification of third parties and the release of information to third parties about mental health services provided to the individual.

The bill requires psychiatric community programs, as part of aftercare planning required by Health General § 10-809, to notify individuals prior to their discharge of the advisability of an advance directive for mental health services, and if the individual requests assistance **in** developing an advance directive, either to provide such assistance or to refer the individual to an appropriate community resource for assistance. Finally, HB 752 requires the Department of Health and Mental Hygiene to provide training, sample forms, and information on advance directives for mental health services to assist programs in complying with **the** requirements of the law.

HB 752 represents the culmination of a three year effort in Maryland to identify and implement measures to promote consumer participation in mental health services. In 1998, the Mental Hygiene Administration established a Workgroup to consider the advisability of legislation for outpatient civil commitment and "such other measures as may be appropriate," and in December 1999, at the direction of the General Assembly, the Workgroup issued a report detailing its findings. The Workgroup consisted of representatives of the Mental

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Hygiene Administration, the Office of the Attorney General, the National Alliance for the Mentally Ill, the Courts, Johns Hopkins Medical School, University of Maryland Medical School, the Maryland Association of Psychiatric Support Services, On Our Own of Maryland, the Maryland Council of Community Mental Health Centers, the Mental Health Association of Maryland, Sheppard Pratt Health System, the Maryland Disability Law Center, Baltimore Mental Health System, and the Maryland General Assembly. After meeting twelve times, examining laws in other states, reviewing the pertinent professional literature, and hearing from three national experts, the Workgroup concluded that legislation for involuntary outpatient civil commitment would not be advisable. Rather, the Workgroup recommended further development of assertive community-based services for individuals at high risk for repeated hospitalization, homelessness, criminal arrest, or self-injurious behavior. The Workgroup also concluded that the Mental Hygiene Administration should promote the execution and use of advance directives for mental health services.

In contrast to outpatient civil commitment (which tends to put consumer and provider as adversaries), advance directives by design promote consumer participation (and cooperation) in planning treatment. In a recent report on the vagaries of outpatient commitment, the National Mental Health Association declared that "the enactment of advance directives legislation can be a step in the right direction and should be pursued at the same time as we work to improve funding for community-based care and against the implementation of . . . outpatient commitment provisions." (Ingoglia, "The Rise of Involuntary Outpatient Commitment Statues: An Overview for Advocates, "Vol. 2 No. *3, National Mental Health Association State Advocacy Update* ***2 (1999)).***

An advance directive (aka "durable power of attorney," "health care proxy," and "living will") is a legal instrument that an individual may execute to establish his or her wishes for treatment should he or she become incompetent or otherwise unable to make those wishes known at some time in the future. The advance directive may present detailed instructions regarding care to be given should certain circumstance arise (e.g., a mental health crisis), or it may designate another person – an agent, or "proxy" – to make treatment decisions on the individual's behalf, consistent with the individual's expressed preferences.

Advance directives, of course, may be used to specify not only treatment to be provided but also treatment to be withheld. It should not be possible, however, for an individual to forbid his or her subsequent involuntary psychiatric hospitalization. If a competent individual may be committed over objection (as he or she may be under Maryland law), it would make no sense to preclude the commitment of an incompetent individual simply because he or she voiced an objection when competent. The same would be true of involuntary medication of a committed patient, under Maryland law.

Advance Directives for Mental Health Services have been praised as a tool for promoting consumer participation in mental health treatment. (Szmukler, "Ethics in Community Psychiatry," in *Psychiatric Ethics,* Third Edition, Eds: Bloch, Chodoff, and Green, Oxford University Press, 1999). Because the consumer (typically in collaboration with his or her therapist) dictates the terms of an advance directive, it is widely believed he or she will be invested in adhering to its terms. A recent English study found that 78% of individuals who developed a "crisis card" or "joint crisis plan" (akin to an advance directive for mental health services) reported feeling more involved in their care and likely to continue with treatment. (Sutherby et al, "A Study of "Crisis Cards" in a Community Psychiatric Service," *97 Acta Psychiatrica Scandinavica* 1 (1999). Individuals who developed a crisis card experienced a 30% reduction in hospital admissions in the first year thereafter (Id.).

The Mental Hygiene Administration is developing sample forms for individuals to use in preparing advance directives for mental health services and will offer training and other support beginning this summer for facility personnel, community mental health providers, consumers, families, advocates, and others interested in making their own advance directives or assisting others.

Springfield Hospital Center's Mental Health Celebration and Awareness Walk — *"Walk For Your Mental Health,"*
on May 11, 2001
from 10:00 a.m. – 2:00 p.m.
Kick-off at 10:00 a.m. in the Geriatric Auditorium.
RSVP (410) 795-2100 ext. 3693.

MHA to Launch School-based Mental Health and Violence Prevention Initiative

By Tom Merrick

The Mental Hygiene Administration (MHA), on behalf of the agencies of the Subcabinet for Children, Youth, and Families, has been designated to take the lead in planning a grant program for developing "School-based Mental Health Promotion and School Violence Prevention Programs." This planning activity was started in anticipation of the authorization of two million dollars in the MHA FY 2002 State budget for this purpose. In addition to the agencies of the Subcabinet, the program has had strong and consistent support from the office of Lt. Governor Kathleen Kennedy Townsend and the Maryland Safe Schools Steering Committee.

MHA has also been awarded a federal grant from the Center for Mental Health Services (CMHS) called "Maryland's Partnership for Safe Schools" to provide technical assistance support and evaluation of the State funded program. The grant will bring the Mental Health Association of Maryland, the Maryland Coalition of Families for Children's Mental Health, Johns Hopkins University and the University of Maryland's Training Collaborative together, as partners with MHA and the agencies of the Subcabinet, to assist with implementation. The combination of State and Federal support promise to make this project an important and exciting opportunity for quality program development in a critical area of need.

The purpose of the grant program is to develop or enhance broad local partnerships composed of local agencies, school systems, teachers and pupil service staff, parents and family members, students and student organizations, as well as an array of civic, cultural, advocacy, faith, and other community organizations. The purpose of these local partnerships is to plan and implement evidence-based mental health promotion and violence prevention activities in schools. This movement toward evidence-based practice is part of a larger MHA initiative on the same topic, as well as the theme of our 2001 Annual Conference in May. The school-based focus of this program has been broadly defined to include elementary, middle, and high school levels and a variety of early childhood settings, including Head Start, and other specialized educational settings.

The local partnership envisioned by the State includes a highly coordinated and collaborative venture involving, at a minimum, the Local Management Board (LMB), Core Service Agency (CSA), Local School System (LSS), and Local Health Department (LHD), in addition to the non-governmental constituencies outlined above.

A Request for Letters of Interest has been distributed to each of the administrative heads of the agencies listed above in every county across Maryland. Letters of Interest from counties were submitted to MHA in mid-April and will be reviewed by an interagency panel of State staff and private experts. Further technical assistance on proposal development will be provided over the summer.

The partnership projects envisioned in this program will be developed and funded during the upcoming school year, and additional information on the program's progress will be provided to interested parties throughout the coming months. For more information on this program, please contact me at (410) 767-6649.

Baltimore Crisis Response, Inc.

By Steve Barron

Since the Baltimore Mental Health Systems' establishment of Baltimore Crisis Response, Inc. (BCRI) in 1993, BCRI has been providing a range of mental health crisis services to the residents of Baltimore City. The following clinical case synopsis illustrates the unique roll that crisis services can play in an overall system.

On February 27, 2001, two members of the BCRI Mobile Crisis Team, Robert White and George Leary, responded to a request for service from Johns Hopkins Day Hospital Program. The client was experiencing an increase in paranoid ideation and auditory hallucinations of the persecutory type. During the interview, the client indicated that he had been hearing voices from his home heating system and, in order to decrease the voices, he "disconnected" the heating system. The heating system was a natural gas system. BCRI contacted the Baltimore Gas & Electric Company (BGE), who said they would be at the client's house in an hour to check out the safety of the home. The client agreed to begin treatment with BCRI and was then transported to

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his home to get some clothing and await the arrival of BGE.

Upon arriving at the client's home, BCRI staff opened the front door and found a strong gas odor permeating the residence. They left the building and waited for BGE to arrive, leaving the front door open to ventilate the home. When BGE failed to arrive in the prescribed time period, BCRI staff flagged down a passing police car. The fire department was notified through police dispatch and arrived shortly after contact with the police. The fire department disconnected both the electric and gas services to the home and then vacated the home. BCRI staff at that time escorted the client to the Crisis Residential Unit for services.

As the preceding case demonstrates, there is a close link between crisis services and public safety. The strength of the BCRI model comes from the ability to provide a flexible range of services from telephone intervention to mobile crisis team response. In this situation, the Mobile Crisis Teams' alertness and willingness to act averted a potential tragedy for the entire community.

To learn more about BCRI, call the 24-hour hotline at ***(410) 752-2272.***

MENTAL HEALTH MONTH
Kick-Off Celebration and One-Mile Awareness Walk,
entitled "Dream ***Catcher's Day — A Celebration*** *of* ***Achieving Dreams and Positive Mental Health."***
On May 5, 2001 at Port Discovery, in Baltimore, from 11:00 a.m. until 3:00 p.m. For information and pre-registration to reserve a T-Shirt for the walk, call (410) 402-7517.

Abuse Improvement Initiative

By Kathy King

On January 1, 2001 Medicaid implemented a new Substance Abuse Improvement Initiative (SAII) for enrollees in HealthChoice, the Medicaid managed care program. This initiative, which was proposed by the Managed Care Organizations (MCO's), provides enhanced access to HealthChoice enrollees and opportunities for expansions of provider networks, which could include mental health providers.

BACKGROUND:
At the request of the Drug Treatment Task Force, the Department of Health and Mental Hygiene (DHMH) formed the Medicaid Drug Treatment Workgroup to answer two questions: (1) Are the MCOs appropriately serving HealthChoice enrollees with substance abuse needs, (2) And if not, should substance abuse be carved out and what model should be used.

After many months of working together, the Workgroup made two recommendations. The first was to implement the SAII effective January 1, 2001. The second recommendation was to simultaneously design a carve out of substance abuse services from the HealthChoice Program, with the intention of implementing it as the default option, unless the new initiative proved to be successful. The Workgroup is currently in the process of designing the carve out model.

COMPONENTS OF SAII:
The stakeholders (providers, MCOs and their Behavioral Health Organizations (BHOs), advocates, and DHMH) developed all components and materials for the Initiative. An Educational Strategy Committee designed multiple mechanisms to educate enrollees and providers about the Initiative.

Self-Referral: Any HealthChoice enrollee can self refer for substance abuse treatment to any appropriate treatment provider, even if the provider is not part of the MCO network. A "Self Referral Protocol Chart" provides information on the process that must be used when an enrollee presents for treatment, including the number of preauthorized services by service type, and communication responsibilities of MCOs and providers.

Prompt Payment: MCOs will promptly pay clean bills submitted by providers within 30 days or pay interest. Providers will be reimbursed either at the rate specified in the contract, or in the absence of a contract, the Medicaid fee-for-service rate.

Expansion of Networks: MCOs are willing to contract with appropriate providers, which are DHMH certified addictions programs or independent practitioners for whom substance abuse treatment is within the scope of their practice according to the Health Occupations Act. MCOs may be willing to accept State certification as satisfying the MCO credentialing requirements.

For implementation materials and additional information on the SAII, *see www.maryland-adaa.org* or contact Wanda Belle or me at (410) 767-1442.

UPDATE on Substance Abuse/Co-Occurring Illness Initiatives

By Tom Godwin

Nearly a year has passed since last year's conference on Co-Occurring Illness (Substance Abuse / Mental Illness) which was co-sponsored for the first time ever by the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA). Much has been happening in terms of substance abuse services in general in the State of Maryland and also between MHA and ADAA behind the scenes.

MHA has had ongoing participation in the numerous meetings led by Deputy Secretary Chang of the Department of Health and Mental Hygiene (DHMH), in the formulation of Managed Care Organization (MCO) and Behavioral Health Organization (BHO) improvements (see article on page 5 about the Medicaid Substance Abuse Improvement Initiative). Additionally, MHA has had continual involvement in the DHMH Workgroup given the task of designing a carve-out system in the event that improvements in MCO-BHO managed substance abuse services under Medicaid are not sufficient.

In addition, there has been a Substance Abuse Task Force originating from Lt. Governor Kathleen Kennedy Townsend's Office, conducting a comprehensive study of the effectiveness and accessibility of substance services throughout Maryland. While these findings are emerging and while overall changes in the system are under study, MHA and ADAA have conducted ongoing **meetings,** retreats, and technical assistance sessions in order to expand collaborative efforts in services for co-occurring illness. Once the "dust has settled", much is slated for the days ahead. ■

lote from Editor: Deadline for ubmission of articles for next issue f *Linkage* is **June 3, 2001.**

Congratulations to:

Maggie Lillo on her appointment as the Assistant Superintendent of the Regional Institute for Children and Adolescents in Rockville.

Steven Reeder, MHA staff member within the Division of Adult Services, on his appointment to the Board of Governor's Maryland Chapter, International Association for Persons in Supported Employment.

Sandra Sundeen, MHA's Chief of Human Resources and Staff Development on her upcoming retirement. She will be greatly missed by all. (Be sure to give your best to Sandy before July; her last month with MHA will be June 2001!)

NAMI of Maryland's
"The Spring Family-to-Family Teacher Training"
will be held on May 11-13, 2001 at St. Mary's Conference Center in Baltimore. Interested persons contact NAMI at (410) 467-7100.
(Space is limited).

Linkage

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Contributions are welcome, but subject to editorial change. Please send to Editor at above address.

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